



evolutions

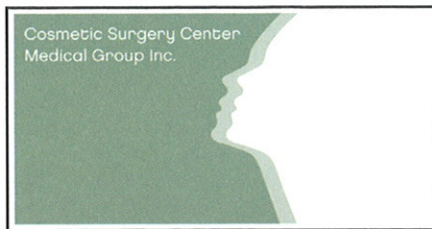
medical spa

BASIC INFORMATION

Name				Date of Birth		Age		Date Today			
				/ /				/ /			
Mailing Address				City			State		Zip Code		
Primary Phone				☐ Cell ☐ Home ☐ Work		Alternate Phone				☐ Cell ☐ Home ☐ Work	
()						()					
E-mail Address						Preferred Reminder Notification (please check one only)					
						☐ E-Mail ☐ Cell ☐ Home ☐ Work					
						<i>Ask about text message reminders too!</i>					
We highly recommend joining our e-mail list. We provide easy appointment reminders. Also, exclusive specials, promotions, and birthday bonuses are only offered via e-mail. Don't miss out! We respect your privacy and will guard your e-mail. You may also opt out at any time. Please Select Your Preferred Level of Contact (check all that apply) ☐ Monthly Newsletter (news, specials, new treatments, event invitations) <i>Frequency: 1x per month plus 1 event reminder</i> ☐ Last Minute Promotions (Ask for details!) ☐ Birthday Bonus (for a special gift on your birthday!)											
Employer						Occupation					
Emergency Contact Name:						Phone: ()					
Reason for your consultation:											
Would you like information about treatment for any of the following? (circle all that apply): Acne Wrinkles Sun Damage Nail Fungus Tattoo Removal Excessive Sweat Unwanted Hair Age Spots Redness (Rosacea) Spider Veins Pigment Problems Teeth Whitening Shape/Size of Nose Thin Lips Eye bags/Excess Skin Face/Neck Laxity Jowls Stretch Marks "Weak" Chin/"Flat" Cheeks											
How did you hear about us? (please circle and include name or additional info where appropriate) Friend or Santa Barbara Phonebook Other Family Independent Publication Business Internet Walk-In Other											
Authorization for Examination and Treatment I, _____, represent to Dr. Perkins and staff that I am at least 18 years old, am accompanied by a legal guardian, or have an appropriate consent form that is signed by a legal guardian. I hereby authorize the clinical staff at the Cosmetic Surgery Center and/or Evolutions Medical Spa to take my medical history and perform any necessary examinations. I also understand that photography is a necessary part of planning and evaluating treatment decisions. I therefore authorize the taking of photographs at the direction of Dr. Perkins or the clinical staff and under the conditions approved by them. The photographs will be used solely for documentation purposes and will be confidential unless otherwise disclosed and agreed upon. Finally, I agree to be financially responsible for any charges incurred at the Cosmetic Surgery Center and/or Evolutions Medical Spa. Signature _____ Date _____											



Signature: _____ Date: _____



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SKIN CARE QUESTIONNAIRE

Name (Please Print) _____ Date of Birth: _____ Today's Date: _____

Have you ever seen a dermatologist for your skin? Yes No If yes, regarding? _____

Are you currently using: (circle all that apply)

Retina A (tretinoin) Renova Glycolic acid Other alpha hydroxy product(s) Vitamin C product(s)

What other skin care products are you currently using?

Do you have pigment problems? Yes No If yes, explain _____

Have you ever had Botox or dermal filler injections? Yes No If yes, what and when? _____

Have you ever had laser or intense pulsed light treatments? Yes No If yes, when? _____

Hypersensitivity

Do you have or have you ever had a skin allergy? Yes No If yes, explain _____

Do you have photosensitivity? Yes No

Hormones (female clients only)

Do you have regular periods? Yes No

Are you going through menopause? Yes No

During pregnancy did you ever get hyperpigmentation or masking? Yes No N/A

Vascularity

Do you have broken capillaries? Yes No

If yes, where? Nose Area Cheek Area Chin Area Forehead Entire Face Other _____

Acne:

Do you have any history of acne or periodic breakouts? Yes No

Circle all that are applicable to you:

Pimples Whiteheads Blackheads Acne Scars Cysts Flakiness Enlarged Pores

Ability to Heal:

Does your skin seem fragile or heal slowly when injured? Yes No

Do you scar easily? Yes No Any chronic skin problems? Yes No If yes, explain: _____

Sun History

Do you (or in the past did you) spend a lot of time in the sun (for work and/or leisure time?) Yes No

If yes, roughly how many hours a week do you (did you) spend in the sun? _____

Do you use sunscreen daily? Yes No

Have you or any member of your family had skin cancer? Yes No If yes, where? _____

What bothers you most about your skin? _____

Do you consider your skin type to be: (circle all that apply)

Normal Combination Sensitive Rosacea Oily
Acne-prone Pigmented Dry Aged